

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6008726</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTH LAWN SHELTERED CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>512 SOUTH FRANKLIN BUNKER HILL, IL 62014</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S 000	Initial Comments  Complaint #1643484/IL86464 Complaint #1643513/IL86491  Statement of Licensure Violations	S 000			
S9999	Final Observations  Section 330.1510 Medication Policies  a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medications for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility.  This Requirement is not met as evidenced by:  Based on record review and interview, the facility failed to ensure that medications ordered by the Physician were reordered in a timely manner for 1 of 3 residents (R2) reviewed for medications in the sample of 3.  Findings include:  R2's Physician Order Sheet, dated 5/27/16, documents orders to include, "Simvastatin 40 mg (milligram) tab take one-half by mouth every evening" and "Trazadone HCL 100 mg tab take two tablets by mouth at bedtime for mood or sleep."  On 6/28/16 at 12:45 PM, R2 stated he was out of	S9999			

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>two of his medications because the facility did not reorder them in time. R2 stated the medications were Trazadone and Simvastatin. R2 stated that he received a dose of each medication on Friday (6/24/16), but was told he was out and the refill had not come in yet. R2 stated he called the pharmacy about the medications on 6/28/16 and was told it would be 4-7 days for the refill to be delivered. R2 stated he gets all of his medications through the VA (Veterans Administration).</p> <p>R2's Medication Administration Record documents R2 did not receive Trazodone and Simvastatin on 6/25, 6/26, and 6/27/16.</p> <p>E4, Nurse Assistant (NA), stated on 6/28/16 at 11:00 AM that she reordered R2's medication on 6/23/16 and that the medication had not been delivered yet. E4 acknowledged that R2 had been out of Trazodone and Simvastatin for a couple days.</p> <p>E3, Licensed Practical Nurse (LPN), stated on 6/28/16 at 11:15 AM that medications ordered from the VA usually take 4-7 days to be delivered. E3 stated the facility does not have a backup plan for residents who run out of medications and are waiting on them to be delivered from the VA. E3 also stated that the facility does not have a system in place to ensure the medications are reordered in time to ensure residents do not run out.</p> <p>The undated Facility Medication policy does not address reordering of medication to ensure the resident does not run out.</p> <p>(B)</p>	S9999		